ORIGINAL

COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

May 25, 2016
11:00 A.M.
James Thompson Training Room
Cabinet for Health & Family Services
275 East Main Street
Frankfort, Kentucky 40601

APPEARANCES

Sharon Branham
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(appearing telephonically)
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Appearing Telephonically:

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AGENDA

OLD BUSINESS:

EPSDT discussion authorizations

DCBS no approvals of MAP 24, no one to reach out to

Skilled services offered for pediatric patients in the Commonwealth

Conflict-free case management

Regulations for conflict-free case management

Other New Business

MS. BRANHAM: I'm Sharon Branham, Chair of the Home Health Technical Advisory Council, and I will call the meeting to order.

Monday evening, I sent out the TAC agenda, and please make note that I was in a time war because I labeled it May 22, 2015 for some unknown reason. So, for those of you that would like a correct agenda, you will find it here at the end of the table with today's date of May 25th of 2016.

To begin with, our Old Business--first of all, I guess we could do introductions around the room.

(INTRODUCTIONS)

If everybody has had the opportunity to review the minutes of the March meeting, I will take a motion to accept those minutes or if there are any changes, let's so note.

MS. CARTRIGHT: I make a motion.

MS. STEWART: Second.

MS. BRANHAM: Absent from our meeting is Missy Bonsutto, Kentucky Home Care Association, another TAC member.

Let's talk a little bit about

some old business on the denials for supplies because MCOs are requesting denials from Medicare, although Medicare does not generally provide denials for a patient who does not have a Medicare skill.

This is a topic that has been on or about the agenda for a few years now. We spoke with the Palmetto representatives at the Kentucky Home Care Conference last week who reinforced the fact that it's difficult to get denials for agencies to utilize to bill the MCOs with a denial.

So, in light of that fact, we have been instructed in the past to use a 12 code which denotes that the patient is dual eligible and that they are being seen for a non-Medicare billable service and claims are being rejected as not a proper code.

The code was put in place to let the MCOs know that this is not a billable service to Medicare, and those claims that have this code, and particularly, as has been brought to my attention, Aetna, Passport and Anthem are denying them.

So, we would like to have a resolve to this issue or suggestions of resolve to

this issue on allowing agencies to bill dual eligible patients for services they receive which are not Medicare skilled services.

Any suggestions other than give examples to each MCO on denials? I guess because we have been dealing with this probably since November or December of 2011, I would think that we should be able to come to some resolution from the MCOs to their staff that process these claims that the 12 code denotes that this is not billable to Medicare. And although the patient may have Medicare, this is not a skill, so, therefore, we cannot bill it.

So, we would like the ability to have these claims processed without them being rejected for a code that we were given and told to bill with. They're processing with a couple of MCOs but not with others.

So, suggestions from the MCO reps as to what we can do to alleviate this problem?

MR. BOLOS: I'm not familiar with that issue. So, like you said, I would like to see a couple of examples and then we'll get right on it and figure out what it is.

MS. RYAN: And I would say the

same thing from Aetna. I wasn't aware and I would love some examples and we'll get right on it.

MS. CROWDER: And for Aetna as well.

MS. BRANHAM: Okay. I'll give those. I guess, Robbie and Gregg, are we going to work through you guys now since Erin isn't here to facilitate those examples?

MR. EASTHAM: Yes, that would probably be the more appropriate thing is to just send it to me.

MR. STRATTON: Send them over to Robbie. You can copy me if you'd like but Robbie is the one who will make sure they get sent over.

MS. BRANHAM: Okay. Thank you.

Agencies have reported that they are receiving home health denials because providers are exceeding supply limit. And, again, we've been through the greater than $250, no authorization, $500, no authorization, yet, when they're billed, the denial is this exceeds the limit.

And it was our understanding that any time that the items are less than,

depending on which MCO it is, that these claims should process cleanly. So, they're not doing that, and these are claims that have to be resubmitted and time on the phone. And, again, this is something that has been on the agenda for a period of time.

I guess the MCOs should give to us information that they would deny a claim that exceeds the limits for a $250 amount or a $500 amount, and that would be the best way, I guess, for us to alleviate this problem. And, then, if we have that from the MCOs, then, anybody that is receiving these denials, then, we should be able to submit that with the bill and the bill be a clean claim and paid.

MS. RUSSELL: Sharon, I'll start. This is Pat Russell. I know we have some of those. We have been going back and forth with several of the agencies. We did set up a call with Billie and Susan, I think part of your team was on it. And actually what we have done now is we have an outside group that is reviewing our units to determine if those units are, indeed, appropriate or should they be unlimited. So, I anticipate within the next probably two weeks, three weeks, we should have some results back from them at which point

we'll look at what their recommendations are and then let you guys know what we decide as far as that.

As far as bringing it down to the dollar limit so that we could say everything that's within the $500 gets paid regardless, I don't know that our structure can do that because if it's something that's not covered but it falls under five hundred bucks, then, it would still go through.

MS. BRANHAM: But these are----

MS. RUSSELL: But I can't separate one from the other is what I'm saying, Sharon, so, if it's an item that's not covered and an item that's covered all under that $500, but I will go back and look and see what kind of capability our system has.

MS. BRANHAM: Billie, one of your staff or through the Alliance submitted to me this question because I guess that the call was in April sometime and there hasn't been any followup or any processing of those claims. Is that correct?

MS. DYER: Yes. I'm here. Can you hear me?

MS. BRANHAM: Yes.

MS. DYER: I'm not aware of that situation or being resolved. I'm not sure which agency that was but nobody directly contacted me about that or spoke to me, Sharon. So, I'm not sure. I'd be glad to help follow up or facilitate however I can on it.

I just know it's extremely confusing to have all those restrictions on there. People are always up in the air trying to figure out what we can order or what we can't.

MS. STEWART: We had that issue and ours is not resolved yet, if that's your question.

MS. BRANHAM: So, there has been an outside source hired by WellCare to review these claims?

MS. RUSSELL: What they are doing is they are reviewing the limit maximum we have set.

MS. STEWART: So, they're reviewing your criteria.

MS. RUSSELL: Our criteria, yes.

MS. STEWART: And if they come back and say you're wrong, what happens? Don't

know?

MS. RUSSELL: I don't know.

MS. STEWART: But if they come back and say you're right but we have the understanding that it should be covered, so, then, we're SOL?

MS. RUSSELL: I don't know the answer to that one either, Susan. It's one of those things we're going to have to figure out once we know what they say.

MS. BRANHAM: And I guess the frustrating component of this is we have been here since November of '11, and it seems like I could just change the date on the top of the agenda because they're the same issues.

I thought all providers have the manuals from the Managed Care Organizations in regards to what is an allowable and what is an unallowable billing for medical supplies, and this is basically where we are focusing this discussion at currently, and here we are again dealing with what's allowable and what's not allowable.

So, if we're going to proceed and have these kinds of issues worked out, then, we need to know what's allowable and what's not

allowable or what limits are there or not limits are there because we've always been told limits are soft, but, yet, we bill them line item and it's under the amount and it is a covered service, then, what are providers supposed to do?

MS. STEWART: I think my question would be for Gregg. At what point do you all on your side say enough is enough with our frustration with the MCOs?

MR. STRATTON: Well, you would have to send us some specifics and let us look into it because I'm not aware of it until today except for what's been in the minutes.

MS. BRANHAM: So, should we ask the MCOs to give us their covered and non-covered listing for medical supplies so that everyone knows that----

MS. STEWART: Isn't it a Medicaid what should and shouldn't be covered?

MS. BRANHAM: I'm just trying to say, okay, here it is, okay, here it's not, and then go forward.

MR. ABREU: This is Juan with CareSource. If it's on the Medicaid fee schedule and it's priced there, I can tell you that it's

covered. So, if you want to provide specific examples, I can do further research and for whatever reason it's not on that list.

MS. BRANHAM: Okay. Well, in light of that, I guess that as a committee, we will attempt to give each MCO what they say they will cover and not cover, and then you tell us and then we can go from there along with providing specific examples to Gregg of denials for limits versus dollars.

I mean, it's been both ways and we have been trying to work through this but we can't seem to get this in a concrete fashion that agencies know they can bill this and provide this or they can provide this, bill it, and although it's covered, it be denied.

I don't know the easiest way and I'm open for suggestions to communicate the easiest way to remedy this.

MS. RYAN: This is Kathleen from Anthem. For me, it would be helpful to see claims to understand what is denying if there are any from Anthem just so we understand where the issue is because it may just be a claims issue and not a coverage issue. So, I would just like to

understand where the problem is.

MS. BRANHAM: Generally, those denials will say it exceeds the limit, although agencies in good faith bill it when it's under the limit or a covered--when we follow the State health plan, it's a covered item under the limit for the State health plan.

Okay. The takeaway from that is we will get the specific denials that shows it's a denial for limit versus item, and we will process through Gregg and Robbie and direct to the appropriate MCO. And, then, at our July meeting, you all can have that information for us.

Incontinent products with T codes are not processing for home health providers to the MCOs. And if they do not process with a T code, do MCOs have another code they would like us to use so that we can bill this and be paid appropriately?

MS. RYAN: This is Kathleen from Anthem. I'm not aware it's an issue. I know we have T codes. So, if you've got examples for Anthem, we'll be happy to look at those.

MS. BRANHAM: And all MCOs recognize that T codes are used for incontinent

products but request specific examples.

MR. BOLOS: I know I had an example this week. Someone called me, a home health agency - I can't remember which one it was - and it was the T codes for two separate dates and they said why is one paying and why is one not. And after I looked into it, they used two separate T codes. So, I sent it back to them and said why are you----

MS. BRANHAM: Was one for an underpad and one was for----

MR. BOLOS: I don't know what it was. But, anyway, so, I put it back on them, but I know we cover them. So, if we could see examples, but I'm not for sure. That other code she gave us looked like it wasn't covered.

MS. BRANHAM: One code----

MR. BOLOS: One code was covered and one didn't look like it was. Anyway, I put that back----

MS. BRANHAM: You don't know the products. You didn't----

MR. BOLOS: No. I've just put it back to her and said why are you filing two different T codes.

MS. BRANHAM: Well, we bill

depending on what the incontinent product is.

MR. BOLOS: Well, she seemed to think they were both the same T code in that instance.

MS. BRANHAM: But it was not.

MR. BOLOS: No. Anyway, that would be nice if we could just get you a list of the T codes covered.

MS. BRANHAM: Okay. Then, I'm requesting that the MCOs provide T codes that are covered to us by the next TAC meeting. You can send them to Gregg and Robbie or to me.

Talking about prior authorizations with MCOs, and, again, I'm banging the drum, skilled nursing services, prior authorization has been given in generally an appropriate turnaround time, yet, the therapies are coming by mail. Authorization for therapies are coming by mail and it can take up to two weeks.

And this is important when patients are being discharged from nursing homes or from the hospital and they've had a knee or a hip and therapy needs to start sooner rather than later.

And we've asked this before as a committee to the MCOs, and I don't guess there's

been a remedy put in place by the MCOs in regards to expediting the prior authorization for therapy services to begin.

And if it's a therapy-only patient, then, the patient has a longer length of stay in their respective provider prior to coming to home health.

I do know that some MCOs fax. Do you all know as the MCO representatives if you all fax the prior authorization for PT, ST and OT or do you do them mail?

MS. RYAN: This is Kathleen, Anthem. I would say that we always review within, if it's an urgent, we're going to do it expedited. We look for those discharged cases so that we're working them quickly.

When we do approve, we submit either a phone or a fax response the day it's approved and it's followed up with an approval letter, but we always communicate the day of approval. If it's a fax request, we usually fax back the response.

MS. BRANHAM: And if it's a phone, you give that.

MS. RYAN: Yes.

MS. BRANHAM: Okay.

MR. ABREU: This is CareSource. We also respond the day that we make the decision either by phone or fax and then we follow up with a letter. And if a request is urgent and it's marked urgent, we treat it that way.

MS. BRANHAM: So, is it important from the MCO's perspective if urgent is marked on a fax request or a verbal request that lets you all know that it should be processed immediately?

MS. CROWDER: Are you just referring to the discharge planning aspect of it?

MS. BRANHAM: Well, both actually.

MS. CROWDER: Because if it's discharge, we prefer that you put that on there and they know that that moves it to urgent.

MS. STEWART: Say that again.

MS. CROWDER: For the ones that are getting discharged from the hospitals, if you put in your request and state that this is a discharge so that it gets moved up to urgent and they know to process them quickly.

MS. BRANHAM: Others?

MS. RUSSELL: We fax back our response. Our decisions are made within the 48-hour time frame or 24 if it's marked as urgent or we perceive it to be urgent, and then we follow with a letter.

MR. BOLOS: And Passport, we will either call back or fax back the same day usually.

MS. BRANHAM: New Business. At the March meeting, I charged the MCOs to provide to the TAC their written process in place for EPSDT clients and authorizations for their services.

And we've talked a lot historically in these meetings about medical necessity, services ordered and the time that it takes to prior authorize requested services.

And oftentimes agencies are given a small amount of visits, particularly on the therapy side and the fact that these are children who don't have much movement in two or three visits.

So, the request was made for the MCOs to provide to the TAC for providers in Kentucky about EPSDT. And really I received a reply from everyone within the time frame - thank you very much - but I didn't receive any step-by-step process

for EPSDT and a plan of care.

What I did receive was that the PA is required regardless of age or the program for aides, private duty, social worker and PT, ST and OT after the twentieth visit per benefit.

So, I didn't really get what we were looking for to alleviate staying on the phone and requesting visits for these clients. WellCare is the one that did agree for a six-month plan of treatment. Of course, we all know they're medically necessary, but I didn't get a step-by-step.

So, with that being said, all MCOs cover the EPSDT services and they don't deny the services, but it's difficult to ascertain about getting any kind of agreeable plan of treatment for an amount of time.

We would be amenable to a two-month or a three-month authorization for a plan of care. And, of course, if any changes are so noted, the MCOs would be notified of that, but we really didn't get that.

What is happening is there are a large number or the providers for EPSDT are dwindling in relation to the burden for providing

these services and the ongoing requests for authorization.

So, what I had hoped was that we could work together to receive a two-, three-month, you know, two to three times a week for therapy prior authorization but we really didn't get that.

So, I was a little bit disappointed in that respect; and in my email to the MCOs, I did state that we know that it's medically necessary or the child would not be entered in the EPSDT Program. We already know who we are dealing with.

And if we're calling for authorization for an EPSDT child and we submit the information that these children, it's medically necessary that they are receiving the service, and then we get four visits, it's very difficult to provide the service and call in two weeks and get four more visits.

And, really, we feel like it's more rationing of services to this particular group that utilizes this service rather than working together to be sure that these kids get the service and the provider can provide it without an

obstructed amount of paperwork and time spent on the phone.

Any suggestions or breakthrough on this for us?

MS. DYER: Sharon, can I add just a little something there?

MS. BRANHAM: Sure.

MS. DYER: At a roundtable at Kentucky Home Care last week at the Board of Directors then, it was reverberated just exactly what Sharon is saying. The rationing of visits is what it appears like to most people involved.

And by that, we mean, okay, you might have "x" amount of duration that the visits are being covered, but they're about half of what the requested visits are that are ordered by the physician for the frequency of visits.

So, if you even are fortunate to get a two-month duration of approval and you're requesting two times a week for that time period, what we hear from everybody involved in EPSDT Special Services and we heard at that meeting, correct, Sharon?

MS. BRANHAM: Yes.

MS. DYER: That they're

getting pretty much approval on half. So, it's not specific to one agency. It's not lack of information. It's not lack of medical necessity. It is only getting half of what is requested most of the time is what we understand and it's what we have experienced at our agency.

MS. BRANHAM: And actually the public health departments carry the burden of this providership group. And, again, it's just really difficult to have a physician's order for EPSDT and oftentimes a child has been in EPSDT for a period of time and we are calling with a new authorization for therapy visits two times a week and they will specify what the specific therapy is for eight weeks and we don't get that, or if it's four visits a week for eight weeks, they will give us two visits a week for four weeks.

A plan of care typically, as we said, is 60 days and it goes to six months on EPSDT. And it's very frustrating, and I think this is a group like our other pediatric special service groups in Kentucky that are not receiving the services that they are eligible for. The money is there to be paid for the therapy and it's just really frustrating when you call with an order for

these children and we're having to follow back up more than should be necessary to request visits for these kids.

So, again, I'm asking the MCOs who have put in writing to the committee that it's medically necessary - we know that - and that these visits are approved, yet, when we come to ask for "x" number of visits that are ordered and which is really a plan of care that the physician has set forth and the therapists have done their evaluation that we can't provide.

So, we're looking for some assistance on this still. Any suggestions?

Okay. Then, I'm going to look to Medicaid to guide us. You all are the only ones that can assist us in getting the services for the children that are needed. So, I'm going to look to you guys to assist us in this matter.

Before, Marilyn, didn't we receive longer authorizations?

MS. FERGUSON: Yes.

MS. BRANHAM: And that's a program that there hasn't been any fraud and abuse in and these children are monitored and the therapists are there providing the service and their

notes give us information as to the progression that these children are making.

I guess we're just asking Medicaid to help us with the MCOs in regards to the undue burden that's placed on agencies providing the service.

MR. STRATTON: Sharon, I'll have a representative come for the July meeting. If there are any questions in between, go ahead and send them to me, but the person who can answer that is not here today but we'll get her to the July meeting or somebody in that department.

MS. BRANHAM: Okay. So, I'm going to submit, Gregg, to you a request for at least following historical approval for services for this specific group of children that the State health plan has had in place and it's my understanding the MCOs should probably just mimic that and follow it down the line.

I just don't want to lose any more providers for this special group of individuals but we are because of the frustration.

Billie, would you echo that about the public health departments?

MS. DYER: Yes. I can tell

you that people are very frustrated with it, and what they are frustrated with is what we've probably said at every TAC for I can't even remember how long.

I'm pretty sure that I'm accurate about this, that what it does is it frustrates people to the point, people being the therapists and/or families who have to get permission for an appeal if we appeal the frequency that we get orders. We have to get permission from the family, then appeal it and get the physician involved, and it's just a very laborious task, and people don't have the funds to spend for staffing to try to just continue to request and sort of beg for what the child needs.

We've talked about and anybody can come and see or look at the patient population that is served. It's a very needy population because of congenital anomalies, very severe medical diagnoses that, as Sharon very well said, their progress may only move forward in minute amounts, but overall they have seen movement in their progress.

So, it's a very important program for the State of Kentucky, for Medicaid

Services. I do believe that it probably keeps expenses down overall, but it is just very frustrating to ask for "x" amount of visits that are needed, given the patient population, and to have to just repeatedly call and that's what we're told. I'm told by our coordinator, our clerical person that gets all of these patients preauthed for services that you're welcome to come back.

Well, that's all fine and good, but they need it. It's not like they just need it for a couple of weeks. I wish they did.

And I know, Rebecca, I think you've gained an EPSDT Special Services. I don't know about Susan and Sharon. They do some, I think. One of the agencies in the health department or public home health group has I think 600 children, the last count I knew.

So, collectively, when we add up, it's a whole lot of children served that improves the quality of life for the parents a lot of times. It makes the child be able to be managed at home with the services. Not all of them are that severe but some are, and some of them might not need it as long, but we truly are asking for what the doctor orders. That medical necessity is already

there. We've looked at everything, our own internal documentation, everything that we can possibly do to try to get this to move forward.

Some MCOs are more on target than others for approving what is requested.

MR. ABREU: This is CareSource. Going along with that last phrase and at the risk of sounding like I'm going against the grain or being difficult, our standard practice, especially with this EPSDT population for the reasons that you've just stated is to approve what was requested. Otherwise, all we're doing is creating administrative burden on the provider's side and an administrative burden frankly on my team.

So, again, I go back to specific examples. If I could have specific examples of where we are not following this practice, I'll be more than happy to perform re-education, but I'm not seeing evidence of this on our side.

MS. BRANHAM: Thank you, Juan. That's all we're asking, if we can come to some kind of an understanding that we know the population that we're serving. We have been serving these kids for

a long time in Kentucky and the program was developed to help these children have a better quality of life, communication skills, ability to walk, activities of daily living.

And some of the MCOs in the state are not taking that into consideration when we're trying to follow a plan of care set forth by the therapist and set forth by the physician, and I think they know those children individually that are in the MCOs.

The Prior Authorization Department is sitting there and denying these visits. And, again, we're calling you all more. We're having to appeal the visits, and I think there should be some kind of middle ground that we can reach for this specific population.

So, Greg, again, Juan, one as a followup to you, I'll ask if any are CareSource, and, Greg, we'll put the specifics in writing and mimic the State health plan that we have historically dealt with and see if we can't get the Department to help us provide this care to these kids and then we can have that put to you and then you'll have the correct representative or someone from that department here at our July meeting.

Thank you.

I'm going to jump around a little bit. I'm going to move skilled services down, and I'm going to talk a little bit about the inability of agencies to receive or to have processed the MAP-24's and the 552's and all of that that relate to waiver services.

And we've talked a lot about this in the past and the 1-800 number that you try to call. Before we were able to reach out to specific DCBS offices and ask them to assist processing of the applications for the waiver programs and we were able to have a good working relationship and know what the issues were, and then we can proceed and get approval to get services to these people.

But it's my understanding through the roundtable that we had last week and it's been on the agenda for a long time that relates to this kind of whole MWMA, the new waiver. The conflict-free has been like spinning in a tornado. Folks are trying to use the portal and receive the ticket number and direct families how to go to the office to have their paperwork submitted or if they're denied, what's wrong and tell them what to

take back to the office.

And they go to the local offices and those folks there tell them that there's nothing wrong, but, yet, you can't get your services paid for and you can't get authorization.

And this whole MWMA, the portal, the conflict-free, those kinds of things have put this program in dire jeopardy in the State of Kentucky, and that's about the only way I know to say it.

We have proposed regulations but they cannot be adopted until CMS approves the waiver. And we don't know when that's going to occur because it's on their time line and not ours, but there are many issues that relate to coverage and eligibility and authorization and are we in the old way, are we in the new way, where are we and what do we do.

And I guess now that we know that the regulations are there and that we're still awaiting CMS approval on the waiver, we have some folks that have been hanging out there since January and February trying to get their applications for services approved.

And this affects a large

population that relates to what the Cabinet has control on. So, I guess I'm asking Gregg and Robbie, what shall we tell the providers, the home health providers out there what's going on with MWMA and conflict-free?

MR. STRATTON: Well, I'm going to start with the regulation and the waiver. Right now, everything is held up in limbo, and we expect to go live with the new regulation July 1. That is the most current date. Again, that's tentative subject to change but that's the date we've been given by the Director.

Now, as far as conflict-free, I'm going to let Lori, if she doesn't mind speaking on that.

MS. GRESHAM: Conflict-free, as you all know, came about because of a federal final rule governing Home- and Community-Based Waiver Services. That is not something that they are waiving on at all other than the geographical exception. And from all of our communications come July 1, that will be a requirement.

MS. BRANHAM: As far as these initial assessments if their paperwork is processed from DCBS, who--I mean, I personally have never met

anybody who was contracted with by the Cabinet from I understand the University of Kentucky to do the initial assessments. Where is that at currently, I guess?

MS. GRESHAM: That's me as well. We do have independent assessors for the HCB assessments. That's separate from MWMA. They're each their own initiative.

Those people are currently working with some of the AAA's who have said that, yes, we will jump on that project and work with you all to do that and they are out there doing assessments and they will continue. Come July 1, they will take over that function totally.

MS. BRANHAM: And currently the ADDs are doing it?

MS. GRESHAM: Yes. Some of them have said we will pilot with your nurse assessors and are allowing them to come in and do those pretty much for administrative burden, assistance with that; but come July 1, it will come to the independent assessors.

MS. BRANHAM: You know, I know that my agency has received calls and our number has been given to the individual and they've reached out

and they've called and then we will talk to them about the services and qualification for services and the legal hubbub that goes all around that.

And it seems that the initial assessors are not communicating to these clients that there are certain qualifications and estate recovery, and it's like they're just giving them a phone number to call but they're not giving them appropriate information for them to be able to know what is going to involve if they are a new client for this program.

And when they are told what the qualifications are for this program, they're like, well, we don't want it.

So, I have some concerns about the AD Districts giving appropriate information about the qualification of services. And, then, if the AD District is handing that off to the independent assessors, are they giving them information that they are giving the patient because if they are, then, there needs to be some training related to taking out that step of them feeling like the agency that contacts them to provide the services is telling them something that they've never been told before and, therefore, they don't

want it.

MS. GRESHAM: And I can't speak to the ADDs. I know that they are taking notes to discuss that; but for the independent assessors, their job is not to provide the client. Their job is solely to assess and to submit that to CareWise for determination for eligibility of their waiver. Their sole job is to be an independent assessor and just complete the assessment.

And the other gentleman can take back in regards to the ADD information and what they're giving out. And I'm assuming you're speaking of patient liability, things like that.

MS. BRANHAM: Yes. Yes.

MS. GRESHAM: And our independent assessors wouldn't know patient liability. All they are to do is to go in and assess to give that information to CareWise. The goal of that assessor is not to--they don't determine services.

MS. BRANHAM: Oh, I'm not speaking about determining, but how are they going to answer the questions of these clients if they don't know the----

MS. GRESHAM: Then, they give

them information to where to go to get those answers. They are solely assessors. That is their sole position.

MS. BRANHAM: I think we're missing a step, though, in between someone interested in the program and seeing if they qualify, and, then, that information being given to the independent assessor, and, then, the independent assessor assessing, and, then, an agency that's willing to provide the services goes through the information as well. And, then, they're like, oh, no, uh-uh (negative), we're not going to do that.

I don't know where the communication breakdown is, but I know that it seems to me like there's a lot of time and energy and effort and money spent in this initial process and prospective clients are not understanding all of the program.

MS. DYER: Are you also referring to, what we're accustomed to doing is when we go in and do a waiver assessment and then it's done by--it can be done by whatever the regs say, a social worker, nurse, etcetera, that part of that packet to work through, the assessment is done, but the estate recovery papers have to be signed. I

think that's what you're referring to, aren't you, Sharon?

MS. BRANHAM: Yes.

MS. DYER: So, are the independent assessors--I think that's what Sharon is saying. Maybe I'm wrong, but I don't know if you're understanding that, that you're thinking, Sharon, that the independent assessors, or you have been told so, that they are not explaining that you have to sign an estate recovery in order to move forward with even being reviewed or whatever for this program.

MS. BRANHAM: I think that currently the ADD has been doing this, and I think they're missing a step about this estate recovery paperwork before it ever goes--that the message is put out to these independent assessors to go do an assessment.

And if they do an assessment and they put it in the portal and an agency picks that up and an agency talks to the patient about the admission paperwork, then, you get to the estate recovery and they're like, no.

So, I don't know what we're missing here, but I do think that we're spending

some time, energy and effort that's not necessary if everybody understands how the waiver program works.

MS. STEWART: How does your assessor know where to go?

MS. GRESHAM: They're given a list and say here are the clients that need to be assessed.

MS. STEWART: Given by who?

MS. GRESHAM: The AAA. I've confirmed it's the AAA that has been--not the independent assessor themselves. The AAA has them sign the estate recovery paperwork. I just confirmed that with our assessors.

MS. BRANHAM: So, the AAA has a name. They have to get the paperwork signed by doing a visit.

MS. GRESHAM: How they do that I'm not sure.

MR. GRESHAM: Can I just interrupt for a second?

MS. BRANHAM: Yes.

MR. GRESHAM: The way the process is being done now is not how it will be done in the future. Right now they're just doing a pilot project to see what the (inaudible) is going to do

compared to the 351 currently. That's all they're doing. So, the process as it's moving forward right now is the same as it should have been done for the past however long we've been doing this current regulation.

Once we move to the new regulation and it's approved and final and we have the waiver approved and we're ready to proceed with MWMA and all that stuff, then, the member will sign up in MWMA, either through them or through somebody that can help them with that. They will fill out the application.

I'm 95% sure that the MAP 350 is in the initial application that they fill out. I'll verify that and make sure, but it should be in the initial application they fill out.

Once the application is completely filled out, then, HP looks at it to see which waiver - they pre-screen - to see which waiver it goes to.

Once it's assigned to a waiver and one of my staff says, yes, they meet capacity or meet the qualifications or whatever to proceed, then, DCBS starts their part as far as doing the financial eligibility.

Once that's done, then, it triggers the note for the assessor to go out and do that assessment. Once the assessment is completed, it's uploaded in MWMA. CareWise reviews the assessment and determines whether they meet level of care.

If the member does meet level of care, then, they are sent a letter saying, yes, they do meet and they receive a list of all the agencies they can go to to ask if you will perform services for them and they will contact you.

MS. DYER: I just wanted to say a little something here. From the health department home health agencies that are currently doing Home- and Community-Based Waiver, we have a group called Kentucky Public Home Health Alliance and I'm just president of that. I don't run all those agencies, but we do talk about concerns and how we can work through those.

And the biggest concern--I have two pages back on my desk of concerns about switching to MWMA, the new waiver, whatever the terms are. And the #1 thing with MWMA, if we're going to change effective July 1 to the new waiver, then, we have to upload - again I'm assuming - all

of our patients again into the MWMA. People don't know how to do that now. They can't get in. And when they do contact for tickets, etcetera, just like Sharon is saying, they don't get back to them.

So, we don't even really understand - and I'm just telling you our concerns - that how are we going to make this happen. From an agency standpoint, and I think someone a minute ago - not there - I think somebody that I probably have never seen before talked about that the independent assessors were put in to relieve the agencies of the burden of assisting.

It was never a burden for us to assess. I don't know where that information came from or why that was filtered out there because we never felt like that was a burden. We simply tried to help get the patients the services they needed.

I guess I've never heard really before now today that those independent assessors out there with the AD Districts - I guess that's who mainly they're working with - is a pilot program.

I hear July 1 and I immediately think, oh, my gosh, here we are and this is the end of May and we have all these waiver

patients that we want to take care of and we have June then if this thing does go into effect July 1.

Now, we got emails from Commissioner Anderson that says she is hopeful to go in July 1. So, I don't know how we can turn this thing, really understand is the pilot working. I think we're still back at square one in many ways of not understanding how we're going to roll this out in our own agencies. I'm not trying to be difficult but how are we going to make this work?

Our biggest concern is if the MWMA--I'm telling you when my coordinator tries to train her social worker in the MWMA, she can't get on long enough to help train her. So, there are issues and problems that I honestly would have to say from all my years from those agencies that feed the information to me and from what I hear from my own coordinator that there are issues that we have repeatedly for months talked about and they're not resolved. We would not be ready to report into that program.

MR. GRESHAM: I tried to write down things as you were going along.

MS. DYER: I'll be glad tomorrow to forward to you and to Gregg.

MR. GRESHAM: That would be great. First of all, any tickets that you have sent in to the MWMA box that has not gotten corrected, we would really like you to email those to us so we can get them corrected because what we're being told on our end is they're all resolved. They're obviously not all resolved; but until we get that information from you, we can't correct it. So, if you could send that to Gregg, then, we will work on that.

MS. DYER: I appreciate it because I don't think we've been told that before to get that to you. So, we'll be very happy to do that. I will email Kristen right now and tell her to start getting those together.

She may have them resolved now, but the laborious task of getting them resolved has been amazing at times, most of the time, all of the time from what hear, but I have about a page of concerns that collectively the Kentucky Public Home Health Alliance came up with at our last meeting. Would you like me to send that list to you?

And it's not anybody trying to nitpick. We're really concerned. We're mainly concerned how it's all going to work for the patients, too.

MR. GRESHAM: Yes, ma'am. We would like that document as well.

MS. DYER: Okay. But whoever thought that the assessment was a burden on the agencies and won't let us do that anymore, that is not true. It was not a burden. As a matter of fact, I think it helped expedite getting people in the system.

Now they're getting hung up at DCBS to the point that I'm telling--you know, I don't know what else to say but call the Ombudsman and she can't even get through to the Ombudsman on one case that she's working on.

So, everything that we're having problems with I'll have Kristen outline, Gregg, and I will send you those concerns. It's the same thing Sharon just said but it's just many more people saying this.

MR. GRESHAM: Okay. And also I just wanted to let you know as well as everyone else, before we go live, there will be communications sent out to all the providers to let them know when things are going live, what's going to happen and to try to prepare everybody as much as possible and to give you an ability to contact us if

you see something we missed.

MS. DYER: Okay. I just confirm with my Home- and Community-Based Waiver coordinator that, yes, the MAP 360 is in that initial packet. I thought it was but she says it absolutely is. So, okay.

So, then, if we're saying that everything is going forward on July 1, then, really, it can't go forward on July 1 because nobody is going to have time. We're going to run into the same thing that we ran into last year when EPSDT tried to turn on July 1.

And with staffing and people on vacation, you can't make all that happen that quickly. There's people that have got, oh, my goodness, 150--I mean, some of these agencies have way more than that because they do the attendant care already, the LPN's and that kind of thing.

I mean, I'm not just speaking for us and the agencies I know in public home health but the private agencies that do the nursing part, that's going to be really hard to turn on a dime and get in that system with it not functioning correctly because I'm telling you, I hear from everybody, and most people are not even trying to use the MWMA

because we were told we didn't have to and they had so many problems with it that they just stopped even trying to use it and we were going on through like we always had to try to get the services for patients that we could.

So, we're at square one in my opinion.

MS. BRANHAM: Well, we all know that the software has had problems and problems that have also existed is you get a ticket number and you try to call and the people who are supposed to assist you with the ticket number don't know what they are. I've had a couple of the folks involved with the software trying to help providers understand this whole process. It is not going well.

And, again, I'm going to go back to the ADD. The ADDs are not vetting any people who they are putting out the door for services. And I have been to the ADD on training when Commissioner Anderson traveled around a year or two ago to all the places. I just think that we've got a real communication breakdown in this whole process.

And just to reiterate, the

patients that are already receiving services and if they're on services and the magic date of July 1 actually happens, are they going to continue to function under that plan of care until they are reassessed and then re-entered into that program? So, I do understand it is the grandfather there with preexisting patients, correct?

MR. GRESHAM: Yes. They have to continue outside the system until they re-assess.

MS. BRANHAM: Okay. I would like for this to work and all providers are willing to make this happen because we know that conflict-free has to and it's everywhere else, but I think between our ADDs or AAA's and these independent assessors and this paperwork, it's not being done as it is written on paper.

So, the AD Districts are not getting anything signed as far as the initial assessment, and on the MAP 350 and the initial application and getting that assigned, they're not doing it. They're just sending referrals to providers. And as I said, the patients don't always understand about the estate recovery and those other kinds of things.

So, any information that you

can give us would be helpful. And as I said, we're here to try to get this worked through, but I really think that we have a backlog.

And that's going to dovetail right into--I know that Professional Home Health Care Agency here in the room has presented an issue that they have 20 patients who are waiting for 552's in order to receive services, and some of these 552's have been in delay for more than four months. So, what is being done to process the 552's that have been outstanding for a period of months?

MS. FERGUSON: I didn't bring it with me, but I have an email address and a 1-800 number that I was given this week, that if you will send it there, they are tracking--DCBS is tracking and assigning those 552 issues and providers are receiving responses back. So, I can either run upstairs and get those or I'll get those before you all leave.

MS. STEWART: Can you get that information to Annette so that we can send it out to the whole group?

MS. FERGUSON: Yes, I will.

MS. BRANHAM: Marilyn, can you get that to Annette?

MS. FERGUSON: Yes.

MS. STEWART: I have I guess more of a statement. It's not really a question. It's to the State people here, and Gregg and I talked about it a couple of weeks ago.

What I expect to happen in my area is the AD Districts are going to become case managers and you're going to have no service providers. We're contemplating what we're going to do. We're kind of waiting to see if this really is going to happen or not, but I'm telling you for my home health agencies' standpoint, we will not be a service provider and let the ADD's just be the case managers. It's not going to happen.

So, I guess I'm giving you a warning. A year from now, home health agencies across the state could no longer be Medicaid waiver providers because of what's going on with all of this.

MS. BRANHAM: Well, it was noted that when Commissioner Anderson came two-plus years ago to this committee meeting and we were told directly that the AAA's were losing money relating to food services or their other assessments that they were doing, that most of it was going to be

given to them and then these 20 independent assessors out there.

And at that time, we told her that some AAA's are better than others and that the ones that function poorly and don't communicate with providers out there, if they're given this duty and they get the money from it and we're stuck with losing money by providing the services, it's not going to happen.

And we did give to Commissioner Anderson different examples in surrounding states whereby a group was brought in to help facilitate and be employed to do this initial outreach for the waiver and the assessments and did a good job at it because they were trained in case management, as opposed to giving this to folks in the AD District, and, quite frankly, they're not doing so good with it.

So, what I foresee happening is that as reassessments come due after we transition, that those patients will be looking for providers throughout the state.

I have been here long enough to know that 25 years ago when waiver came around with the 1115 Waiver, that certain providers in the

state were given statewide waiver ability to provide the services because home health agencies didn't do it because it's a losing proposition.

And, then, agencies started picking up because the case management would help offset some of the losses in providing the care, but I see that flipping back around and only those that are strong will be able to provide this service and it will probably be on a statewide basis like it was given to Lake Cumberland many, many moons ago, if you remember that, Susan.

MS. STEWART: Vaguely.

MS. BRANHAM: See, I've been around that long. Okay. Just as a----

MS. STEWART: One more thing just to add to that. We get calls every day and sometimes they're from the State begging us to go to an area that we don't provide certified home health in just to become a waiver provider in another county that might be five counties away because another home health agency has decided to get out of the waiver program.

This program - and Marilyn is dedicated to this program and has dedicated her career in Medicaid to this program. She knows that

this program is in dire jeopardy, probably more so than EPSDT is.

MS. FERGUSON: I can vouch for we have contacted you in the past to aks if you would go above and beyond and provide a very needy family some services when they couldn't find a provider in their area. That's true.

MS. BRANHAM: So, I foresee us having big issues that relate to this just so you know.

And brought to our attention as well from folks at Professional, they're having numerous issues with the KY MMIS system. Services cannot be preauthed for health care needs or transport needs.

Patient coverage and eligibility is reported inaccurately creating an access for both health care and transportation needs. They want to know if there is a detour to get services approved until the software is fully functional for the MMIS. And patient names continue to have the first and last name transposed.

Patients' payor sources have been arbitrarily changed mid month with retro assignment dates back several years. And one

patient that they have knowledge about is showing coverage in both an MCO and a Model Waiver II simultaneously.

So, this is kind of what's out there and what is coming down the pike so that you know. Staff has verbalized frustration at this system ongoing as far as their names being transposed and we're not able to make those changes. They have to go to the DCBS office and get those changes made.

And who knows better than the individual going to that patient's home what the address is and what their name is and if they're active than the people that are actually doing it versus the informational dump into the software.

I have been hanging with waiver for a long time myself with Marilyn, but I really see that this is what is out there brewing and what is coming and we have been bringing it to the Cabinet's attention but I'm not so sure that any headway has been made on any of this, so, just so you know.

MR. GRESHAM: Do you have any specific examples you can send me?

MS. BRANHAM: I'm sure that--

yes, Gregg.

MR. STRATTON: Well, I've got some, Earl. I've received Darlene's pipeline. Every time something comes up, she will send it me. I try to send it down the line. A lot of times I will send it over to DCBS or send it to MWMA and we pick them off one at a time slowly, but we haven't seen any resolution or no sign of resolution.

Occasionally, John Hoffman will take care of some for me and Robbie has gotten some. I send some down to Glen Sharp. So, we're doing them as they come in but I don't know if they're all tied to the same issue. I don't really know.

MS. BRANHAM: So, it's not out there working like it's supposed to be.

MR. STRATTON: What's that?

MS. BRANHAM: As far as the information that was dumped into the system and, then, the backlog that's out there. I mean, I can go through the litany of issues that relate to this, and I'll start with software. I'll start with incorrect information in the system. I'll start with lack of knowledge about tickets. I'll start with the software kicking you off as you're trying

to enter information. I mean, I can go down the line, so, just making you aware.

Talking a little bit about - and I've been sending these to Stephanie and I know two months ago when I said you call and get a prior authorization with an MCO for services. You provide those services, and this could go on for three or four or five months or eight months or ten months or no real time limit there.

And you're billing these services and you're being paid and you're being paid, and, then, suddenly you get a denial and you get a demand recoupment letter from an MCO because that patient was not on their roster five, ten days mid month and they have been switched back to the State health plan or they've been switched to another MCO.

And, so, Stephanie's suggestion was to check their eligibility before you make every visit which is not humanly possible. And if you assume at the first of the month all agencies check eligibility before we go, but we can't do it every time we make a visit because we have those visits authorized and we assume that the MCO that authorized those visits is the MCO that should have

authorized those visits. And then you do a billing and it's like, no, uh-huh, no, they're not our client, and this can go back----

MS. CARTRIGHT: I've got one for '15. I just got it.

MS. BRANHAM: And it does happen. So, I have been sending those to Stephanie and I actually said, do you want every one of these that are sent to me in regards to this because it is happening, and I don't know where the glitch is.

Sometimes they will switch two and three times in a month or in a three-month period they will switch and you don't know if they've gone to the State health plan or they've gone to another MCO or what is occurring but it does occur.

We have examples. I provided examples to Stephanie and I guess Rebecca brought one today. Did they switch only one time or three months?

MS. CARTRIGHT: This patient was on our service from April to May of 2015, and we just received something in the mail from Aetna that this patient was actually retroactive under traditional Medicaid on 12/10/15, and then they

backdated the coverage to 1/1/15 through 1/1/16. And, so, we're looking at a $1,204 writeoff, and, then, Aetna has recouped $408, but we just received this on a patient that we have all the proof that we checked eligibility for in '15.

MS. BRANHAM: So, it is occurring and we don't know why. Do y9ou all have any answers?

MR. STRATTON: I don't. Can I have a copy of that?

MS. CARTRIGHT: Yes, I will give you this.

MS. BRANHAM: So, again, it leads to time that should not have to be spent in dealing with issues such as that, and I don't know what to do other than to feed them to Stephanie. Gregg, is that where----

MR. STRATTON: I would send them to Stephanie and that's who I was hoping would be here today or Cindy Arflack. They would have a little bit better response than I would.

MR. GRESHAM: But if you could also call BS because of being waiver members.

MS. BRANHAM: Thank you. But it does occur, and if it's retro, I mean, the

suggestion to check eligibility before you go perform a visit doesn't assist that in any way because it comes out and it's retroactive and they revert it back to a time that you had no clue.

So, we've got a glitch somewhere and it's causing some frustration.

Trying to move along----

MS. DYER: I might add to this. We had a situation just like this, a patient in waiver that flipped in the middle of the month to an MCO and somehow that is causing problems getting other services, even medication.

MS. BRANHAM: Yeah, it goes back to it could be a hospital stay, it could be a doctor's visit, it could be the pharmacy. It affects not just us as providers but across the board when that eligibility is flipping around like a tadpole.

MS. DYER: So, the whole care of the patient is kind of what I'm saying there and the same thing everybody else is saying. So, if we're trying to keep people in their homes and out of the nursing home, it's really causing problems.

I will ask Kristen, Gregg, to include that scenario in her letter that we're going

to try to get out by Friday.

MS. BRANHAM: Thank you, Billie.

MS. DYER: And she can send it to Stephanie also but just so you can see it specifically there. Okay?

MS. BRANHAM: Cindy and Stephanie.

MS. DYER: I don't know if we have both of those contacts. Can that be sent out by Annette to everybody so everybody knows who to send it to?

MS. BRANHAM: Sure. Trying to wrap this up, we've kind of talked about New Business, the regulations of the conflict-free and the conflict-free and the issues with the paperwork relating to waiver services. Then we've talked about flipping back and forth and the issue that that results in.

And a couple of more things that have been brought to our attention is home health agencies that have medical directors can acquire and order and administer hydration fluids with specific HCPCS codes after the physician's order and the cost-effective method of keeping the

patient rather than an ER visit or an admission for simple rehydration.

In the prior services manual, IV therapy supplies including solutions unless a drug has been added to the solution can be filled by the pharmacy were covered and paid by Medicaid. After the publication of the fourteen Schedule of Supplies mentioned, no code was assigned.

So, we have this copy of the Home Health Services Manual for a reference. And can you guide us on the specifics that may have changed there; and if so, give us a directive.

MR. STRATTON: When Marilyn comes back, let's direct that question to her.

MS. BRANHAM: Okay. And gloves were omitted from the Home Health Schedule of Supplies, but regulation 907 KAR 1:030 was amended and gloves are reimbursable under specific HCPCS codes and we're wondering what happened there.

MR. STRATTON: They're not a covered item.

MS. BRANHAM: They're part of doing business. Gregg, do you want to give us a directive on that to put out to providers that they are a non-covered item?

MR. STRATTON: Sure. We had that addressed the other day from our DME person here at Medicaid and I can just have him give a little bit better response. I sent it on to Professional Home Health when I received it, but I could forward it to the group if they would like that.

MS. BRANHAM: Okay. Yesterday, I think most people received a directive from the Cabinet that with this transition of therapies going stand-alone, that there's going to be a couple of workshops next Tuesday and Wednesday about this transition to help guide them.

Anything you want us to know as home health providers or is this directed just as independent therapy models under the new program?

MR. EASTHAM: Mostly it's independent therapy models. I will tell everybody, there's been one question about the webinar link. They keep asking me when are we going to put the link up or where is the link, and it's going to be posted on the DMS website when it gets closer to the date. Oh, wow, it's pretty close anyway.

MS. BRANHAM: It's coming soon.

MR. EASTHAM: I'm not 100% sure.

MS. GRESHAM: It's usually 30 minutes before it is opened is when they will post that link.

MS. BRANHAM: So, it's going to be 30 minutes prior to the sessions.

MS. GRESHAM: That's usually when they post it for all the webinars I've ever done.

MS. BRANHAM: On the DMS website. Okay.

Most providers are receiving provider letters about July 1 reimbursed for waiver. All new waiver providers and new--existing providers must be compliant with the final rule. And I guess the final rule, is that what we had, Gregg, from you but we're still waiting approval from CMS?

MR. STRATTON: On the final rule?

MS. BRANHAM: This provider letter that agencies are receiving.

MS. GRESHAM: This is regarding new waiver settings. This is guidance directly from CMS that if you are putting up a new

setting. So, for instance, for you all, it would be an ADHC, or for the HCB Waiver, would be an ADHC. If they billed a new ADHC now, it must be fully compliant with all of the final rule, federal regulation or we cannot make that a Home- and Community-Based provider, so, if any new setting that is built.

MS. BRANHAM: That's strictly because it lists different entities that it seems to affect.

MS. GRESHAM: Yes. And that's for any new setting for Home- and Community-Based Waiver setting.

MS. BRANHAM: So, this is a provider letter that has gone to Acquired Brain Injury, Adult Day, Home- and Community-Based and Supports for Community Living.

So, I guess it's just guidance from CMS, although when you look at it, you like go, okay, where is the new waiver. It says settings because most people don't open a setting for Home- and Community-Based Waiver. So, I just wanted to be able to put----

MS. GRESHAM: Home- and Community-Based Waiver is all of our waivers. All

1915(c) waivers for the federal government are called Home- and Community-Based Waivers. So, that would include our Home- and Community-Based Waiver, ABI, ADI, LTC, Model Waiver II, SCL, Michelle P. All of those waivers fall under that umbrella with CMS.

For a final rule, they have told us that if there are any new settings which that's their term, a setting is anything. It could be for SCL residential, a new residential setting even with an existing provider or a brand new provider or for our Home- and Community-Based Waiver could be an ADHC, those things. If there's a new setting, they have to be fully compliant with that federal regulation.

MS. BRANHAM: Okay. There's going to be a forum or I guess it was invitation only in regards to pediatric services. I saw an email that relates to that and no home healths were invited, the best we know.

But in preparation of what's going on in the pediatric world and agencies that are providing home health, they're not really providing skilled services and respite care services to pediatric patients, I did put out to the

membership because that's the email I have asking who provides pediatric services across the state.

And we have a pretty good coverage of that, but I understand that's not always the case when families are looking for this kind of care.

MR. STRATTON: And the reason I asked for that to be added was the IDD TAC that they had last week, it was brought up because with the Michelle P. Waiver, we're being limited to forty hours per week of combined services and that's opening up a new market for home health providers to provide private duty nursing to some of those members because they're going to be losing some services.

So, that's why they had brought that up. If they've got up to 2,000 hours a year, who can we get to provide those services? Most of them don't offer for pediatric.

So, if you've got a list, I can send that to Patty Dempsey of the ARC of Kentucky and she can disseminate that out.

MS. BRANHAM: Okay. Anything else?

It would be very helpful if

all the MCOs could give their email address to Annette. Annette will give you her card and you can hand it to the MCOs so that we know who to contact for issues that we're having.

MR. BOLOS: Sharon, can I ask a question?

MS. BRANHAM: Yes.

MR. BOLOS: Could I get a list of the pediatric home health agencies?

MS. BRANHAM: I will send it. That's why I wanted everybody's email here today.

MR. BOLOS: Okay, because that's been a big issue with our members.

MS. BRANHAM: I was trying to head a little bit of that off with getting this information. Give to Annette this information of your email addresses of the appropriate folks and then we'll not only send it to you, Gregg, but we'll send it to the MCOs for providers who say they provide this additional service throughout the state and then we can see what kind of coverage we have. Niki, I will send it to you.

MS. MARTIN: That would be great. Thank you.

MS. BRANHAM: If there is no

further discussion, we will adjourn the meeting except for the fact that we'll make note of the July meeting is to be held the 27th.

With no further discussion, we will adjourn the meeting. Thank you so much for your attendance.

MEETING ADJOURNED